REQUEST TO AMEND
PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request amendments to your protected health information which the Cancer Detection Section creates or maintains. We will act upon your request to amend within 30 days of our receipt of your request. If your request is denied, we will let you know the reasons for the denial in writing. You have the right to disagree with our denial of your request for amendment. You may tell us why in a written statement of disagreement that will be added to your record. If we continue to disagree with your requested amendment, we may place a note (rebuttal statement) in your record on why we do not agree with your statement of disagreement. We will send you a copy of our rebuttal statement. You also have the right, under the Information Practices Act of 1977, to request a review of the refusal to amend a record by the head of the agency or a designee. Mail this completed form, with a photocopy of your identification and documentation of your address (see Page 3), to:

Cancer Detection Section
Attention: HIPAA Manager
MS-7203, P.O. Box 997413
Sacramento, CA 95899-7413

<table>
<tr><th colspan="4">INDIVIDUAL INFORMATION</th></tr>
<tr><td colspan="2">LAST NAME</td><td>FIRST NAME</td><td>MIDDLE INITIAL</td></tr>
<tr><td colspan="2">ADDRESS</td><td>CITY/STATE</td><td>ZIP CODE</td></tr>
<tr><td colspan="2">Cancer Detection Programs: Every Woman Counts
RECIPIENT ID NUMBER*</td><td>DATE OF BIRTH</td><td colspan="2">SOCIAL SECURITY NUMBER*</td></tr>
<tr><td>DAYTIME PHONE NUMBER

(____) _____</td><td>ALTERNATE PHONE NUMBER

(____) _____</td><td>BEST TIME TO REACH YOU

_____</td><td colspan="2">EMAIL ADDRESS

_____</td></tr>
</table>

*We use these numbers to make sure information can be amended only by appropriate persons. If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.

PROTECTED HEALTH INFORMATION YOU WANT TO AMEND

IDENTIFY THE PROTECTED HEALTH INFORMATION IN YOUR CANCER DETECTION SECTION RECORD YOU WANT AMENDED:

WHAT DO YOU WANT THE RECORD TO STATE? (ATTACH ADDITIONAL PAPER IF NECESSARY)

WHY DO YOU BELIEVE THE AMENDMENT SHOULD BE MADE?

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE_____ DATE_____

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 1 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

CDPH is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, CDPH has in place appropriate physical and managerial procedures to safeguard the information we collect.